IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

March 31, 2010

TomWhittemore, Administrator
Communicare, Inc #9 (Main)
40 West Franklin Road, Suite F
Meridian, Idaho 83642

RE: Communicare, Inc #9 (Main), Provider #13G059

Dear Mr. Whittemore:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Communicare, Inc #9 (Main), on March 23, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance

within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **April 13, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

TOM MROZ
Health Facility Surveyor
Fire Life Safety & Construction Program

TM/lj

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G059	A. BUILDING 02 B. WING _____	03/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNICARE, INC #9 (MAIN)	876 E MAIN JEROME, ID 83338

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

The facility is a single story duplex. It is Type V (000) duplex construction and is sprinklered throughout except in the garages and attic by a 13-D extinguishment system. It has a complete fire alarm/smoke detection system. It was built in 1996 and completed in January of 1998. It is currently licensed for 9 ICF/MR beds.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted on March 23, 2010. The facility was surveyed under the LIFE SAFETY CODE 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability and 42 CFR 483.470 (j).

The Survey was conducted by:

Tom Mroz CFI-II
Health Facility Surveyor
Facility Fire/Life Safety and Construction Program

RECEIVED
APR 09 2010
FACILITY STANDARDS

K0152	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. (2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift;	K0152	K0152 We schedule monthly evacuation drills on our annual calendar and the office secretary contacts each home on a monthly basis to verify the drill occurred as planned. In October a drill was not accomplished in this home however drills have been conducted in all previous	3/23/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tom Mroz	Administrator	4-8-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G059	A. BUILDING 02 B. WING _____	03/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNICARE, INC #9 (MAIN)	876 E MAIN JEROME, ID 83338

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K0152	Continued From page 1 (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. (3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. This Standard is not met as evidenced by: Based on record review it was determined that the facility failed to hold evacuation drills at least quarterly on each shift. Findings include: During record review on March 23, 2010 at 3:40 PM, it was determined that the facility did not have any records of conducting the required drills for the third shift during the first quarter and for the second shift during the 4th quarter for the 2009 calendar year. These observations were witnessed and noted by both the facility staff and Surveyor.	K0152	and subsequent months, according to the office record, drills have been held. This was an unusual occurrence. We feel our double check system will continue to assure the drills take place as required and that no further system adjustments are needed at this point.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 000	16.03.11 Inital Comments	M 000		

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The following deficiencies were cited during the annual Fire/Life Safety survey conducted on March 23, 2010. The facility was surveyed under the LIFE SAFETY CODE 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for the Mentally Retarded, (ICFMR).

The Survey was conducted by:

Tom Mroz CFI-II
Health Facility Surveyor
Facility Fire/Life Safety and Construction Program

MM309 16.03.11.110 Fire and Life Safety Standards — MM309

Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by:

Refer to CMS federal form 2567 and K tag K152.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4-8-10